

Wisconsin Department of Health Services

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|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       |                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0016238</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>10/20/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HERITAGE 6 LLC</b> |                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7901 W NATIONAL<br/>WEST ALLIS, WI 53214</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                         | ID<br>PREFIX<br>TAG                                                                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| U 000                                                     | <p><b>INITIAL COMMENTS</b></p> <p>On 10/20/2026, Surveyor completed an abbreviated and complaint survey. As a result, no deficiencies were identified. One of 1 complaint was unsubstantiated.</p> <p>Census: 33</p> | U 000                                                                                    |                                                                                                                          |                                                                    |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE